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MedChi Final Report

April 12, 2010

The 427th Session of the Maryland General Assembly concluded at midnight on Monday, April 12th. The final day brought one of the most surprising and exhilarating victories in MedChi's storied legislative history. On the last day, at 2:15 p.m., the House of Delegates amended and passed Senate Bill 314 (Health Insurance - Assignment of Benefits and Reimbursement of Nonpreferred Providers) and the amendments were concurred in by the Senate at 9:30 p.m. Senate Bill 314 now awaits the Governor's signature.

Assignment of Benefits

The Assignment of Benefits (AOB) legislation has foundered for the last 5 years and although, always supported by MedChi, it became its number one priority when MedChi lobbyists – on the last day of the 2009 Session – persuaded Senate Finance Chair Thomas "Mac" Middleton and House HGO Chair Pete Hammen to send the issue for study by the Joint Committee on Health Care Delivery and Financing. The Joint Committee, after studying the issue over the summer and fall of 2009, produced Senate Bill 314.

Senate Bill 314 was adamantly opposed by CareFirst CEO Chet Burrell, the rest of the health insurance industry including United, Cigna, Aetna and Coventry as well as by the Maryland State AFL-CIO. The legislation had been mired in the House HGO Committee for over one month and it was assumed that the bill would either not be voted on or, if voted on, would be defeated in that Committee. While the opposition was supremely confident in their ultimate victory, and while the MedChi lobbyists were publicly not optimistic, they remained at work on the bill. Their great allies turned out to be House Speaker Michael E. Busch and Insurance Commissioner Elizabeth Sammis. The intervention of these two individuals resulted in a compromise being affected that was hammered out in 24 hours from Friday until Saturday afternoon and which was presented to the House HGO Committee on Monday morning for approval. The Committee unanimously approved, the full House of Delegates consented and the Senate concurred all within a matter of 12 hours.

The opposition was shell-shocked by the HGO Committee turnaround and found an ally in the Maryland Health Care Commission. On Sunday night, Rex Cowdry, the Executive Director of the Maryland Health Care Commission, sent an "over the top" letter blasting the House compromise. This letter became the insurance industry's last minute sword against the bill but it was unavailing.

The contribution of Acting Insurance Commissioner Elizabeth Sammis was particularly critical as she constructed a method of compromise which pleased hospital-based doctors as well as legislative opponents who were concerned that "balance billing" would occur more frequently if network doctors left the networks once they could continue to receive insurance reimbursement directly. The provisions of the compromise which apply to hospital-based doctors and on-call specialists were essentially the same: a "hospital-based" doctor or a "on-call" specialist who accepted an assignment of benefits would not be allowed to "balance bill" the patient but would be guaranteed to receive from the insurance company **the greater of** (1) 140% of the average contracted amount paid for the same service or, (2) the amount that the doctor had received on January 1, 2010. The practical effect of this language was to guarantee hospital-based and on-call doctors an increase in reimbursement from CareFirst and disallow higher paying insurers from lowering their reimbursements over what they were paying on January 1, 2010. In addition, the reimbursements will increase over time with a built in yearly inflation rider.

Approximately 10 years ago, a similar formula had been devised for the payment of non-par doctors by Maryland HMOs. The proponent of that 10-year old compromise was Speaker Michael E. Busch, then Chair of the House Economic Matters Committee. Ten years later, Acting Commissioner Sammis found a similar pathway to compromise.

The final version of the bill (particularly its formulas) are somewhat complicated and will require insurance companies to make calculations to establish the actual rates that they were paying doctors as of January 1, 2010. The legislation will have a delayed effective date and not take effect until July 1, 2011. Senate Bill 314 contains a provision indicating that it is the "intent of the General Assembly" that the reimbursement for doctors not be decreased as a result of the legislation.

The list of "thank yous" is long for the AOB success: Senator Rob Garagiola and Delegate Dan Morhaim as Co-Chairs of the Joint Committee on Health Care Delivery and Financing which developed a well reasoned proposal; Senator Garagiola shepherded the bill through the Senate; House Speaker Busch and Commissioner Sammis effected a compromise which Delegate Morhaim and HGO Chair Peter Hammen made happen. Delegate Ron George as Chair of the Doctors Caucus energized fellow members of the House and Senate in support Finally, nothing would have happened without the outstanding work of MedChi doctors, staff and the Component Executives.

When the American college kids beat the Russian professional hockey team at Lake Placid Olympics in 1980, sportscaster Al Michaels – in the waning minutes of the game – exclaimed "Do you believe in miracles"! This morning, MedChi membership can universally exclaim "Yes."

<u>False Claims:</u>

Senate Bill 279 (Maryland False Health Claims Act of 2010) passed the House of Delegates in the concluding week of the General Assembly but not without a dust up. The passage of this legislation has been a foregone conclusion since the Maryland hospitals agreed to

a "compromise" which enabled the bill to move through the Senate where it had been killed in fierce floor fights in each of the last two years. These amendments limited the qui tam provisions so that a whistleblower lawsuit could not go forward without the state taking over the case. In its amended form, the new Maryland law is not "DRA compliant" (the federal Deficit Reduction Act) and thus Maryland will not be entitled to additional monetary reimbursement from federal fraud lawsuits. Nevertheless, the enacted legislation provides for whistleblower involvement in the imposition of extremely punitive remedies for any hospital, doctor or pharmaceutical company accused of making a "false health claim."

Once the hospitals had reversed position on the bill, the likelihood of stopping its enactment was virtually nil. Nevertheless, MedChi and the pharmaceutical industry fought on. Amendments proposed by MedChi during the final week of the Session received surprisingly strong votes on the floor of the House of Delegates even though they were not successful. These amendments were opposed by the O'Malley Administration and its chief advocate for the bill, Lt. Governor Anthony Brown, as well as by the entire House of Delegates Leadership. One amendment sought to eliminate the "retroactivity" provision in the legislation which would permit lawsuits relating to false claims dating back to October 1, 2000 [Yes, 2000]. Given the vigor of the opposition to this amendment, it is believed that there is a lawsuit waiting to be filed once the new law is effective on October 1st. Opponents of the MedChi "retroactivity" amendment said that it was a "$20 million amendment" meaning that it would take away lawsuits with a value of $20 million. It is virtually certain that the MedChi amendments would have been successful if the hospitals had supported rather than opposed them. As it was, the MedChi amendment on retroactivity fell only 10 votes short (out of 141) of being enacted.

Nevertheless, Maryland has now adopted a state qui tam statute with extremely punitive penalties for those accused of processing false health claims.

Scope of Practice

Nurse Practitioners: The Nurse Practitioners (NP's) introduced legislation (House Bill 319/Senate Bill 484 (*State Board of Nursing – Nurse Practitioners – Certification Requirements and Authority to Practice*) that would have abolished the requirement that the NP have a collaborative agreement with a physician. MedChi strongly opposed this measure. After the hearings, HGO Chairman Peter Hammen made clear to the NP's that the measure as introduced would not pass, while the Senate seemed more inclined to pass something close to what was introduced. After numerous meetings and amendments, the parties reached an agreement which preserves the requirement of collaboration between an NP and a physician. An NP must file an attestation with the Nursing Board that the NP has an agreement which sets forth a plan for collaborating and consulting with a physician, and for referrals. The regulations which will follow require the NP to identify the physician. This approach mirrors that adopted for Nurse Midwives in late 2009. The legislation also codifies the NP's scope of practice, which previously was only set forth in regulation, and allows the Board of Physicians to access an NP's attestation as needed.

Physician Assistants: The PA's proposed a significant overhaul of their licensing act for the second year in a row, and this time they were successful. Most importantly, the legislation

(Senate Bill 308/House Bill 323 – *Health Occupations – Licensure of Physician Assistants*) preserved the requirement of physician supervision of all PA's and that a delegation agreement be filed with the Board of Physicians. MedChi supported the bill with three amendments, all of which were addressed in the final version of the bill.

1. The bill as introduced allowed PA's performing advanced duties to begin performing those duties prior to Board approval. As adopted, only a PA that has already been credentialed by an accredited health care facility can perform advanced duties prior to Board approval. Any other PA with this intent must first receive approval. PA's performing only "core duties" can begin working upon the filing of the agreement.
2. The bill as introduced eliminated the current requirement that a physician see the patient initially if he is being treated for a life-threatening, chronic, degenerative or disabling condition, and as often as the patient's condition requires, but no less than every 5 visits or every 180 days, whichever occurs first. This provision was restored.
3. The bill as introduced eliminated any limit on the number of PA's a physician could oversee in a nonhospital setting. The current limit is two. The bill as passed increased that number to four.

Wellness Practitioners: Senate Bill 357/House Bill 541 (*Health Occupations – Wellness Practitioners – Exemption from Licensure as Physicians*) would have authorized "Wellness Practitioners" to practice in Maryland. MedChi strongly opposed these bills. The legislation provided a "safe harbor" to these practitioners so long as they did not practice certain identified acts covered by the Medical Practice Act. There was no specified education, training, experience, license, registration or even an accrediting organization identified in the bill. While the bill offered one consumer-friendly provision—that of requiring the wellness practitioner to provide notice of his or her education and training to consumers—even that was of little benefit because without some form of registration, the authorities have no ability to check and determine if one of these practitioners has posted such notice. The respective committees (EHE and HGO) saw that this area of "practice" was not ready to be licensed and killed both measures.

Physical Therapy Examiners: House Bill 325/Senate Bill 485 (*State Board of Physician Therapy Examiners – Licensure and Regulation*) would have expanded the scope of practice of physical therapists to include "using x-rays". MedChi objected to this expansion due to the limited training and experience of physical therapists in this area. The Senate amended the bill to remove this expansion, while the House limited the expansion to "taking" x-rays. The bill died in conference committee.

Pharmacists: House Bill 1089/Senate Bill 1053 (*Health Occupations – Pharmacists – Laboratory Tests*) proposed to make CLIA waivered laboratory tests a recognized "scope of practice" of licensed pharmacists. MedChi, the Board of Physicians and the DHMH Laboratories Administration opposed the bill on a number of grounds including that passage of this legislation would further fragment continuity of care and was counter to the goal encompassed in the patient centered medical home legislation. The legislation was ultimately withdrawn, with an agreement that the Laboratories Advisory Committee would review the list of Maryland excepted tests and make a recommendation on how to proceed. Dr. Joseph Zebley

serves on the Laboratories Advisory Committee and felt strongly that this was an appropriate response to the legislation.

Board of Physicians

Discipline of Physicians: House Bill 114 (*Health Occupations Boards - Revisions*) passed, making revisions to the disciplinary processes of all health occupations boards, including the Board of Physicians. Each board must, if it does not already, establish a disciplinary subcommittee that investigates complaints, recommends any charges, and then participates in case resolution conferences. Second, the bill prohibits charges being brought more than 6 years after the basis of the complaint was discovered or should have been discovered. Exceptions are made to this limitation if the complaint involves criminal activity, sexual misconduct, substance abuse, fraud, or acts that occur while a person is a minor. Another exception was proposed for a complainant's "repressed memory", but it was amended out.

Third, when a case involves the standard of care, House Bill 114 allows the licensee 10 days to respond to the finding of the peer reviewers if they note a violation. Fourth, House Bill 114 requires each board to adopt sanctioning guidelines to ensure some level of uniformity in its disciplinary actions. A board may deviate from the guidelines based on aggravating or mitigating factors. Finally, each board must develop goals for the timeliness of complaint resolution.

Cosmetic Surgery: House Bill 870 (*State Board of Physicians – Offices or Facilities for Performing Cosmetic Surgical Procedures*) as passed requires that certain cosmetic surgeries only be conducted in an accredited office or facility. Exempted from the definition of "cosmetic surgery" are any procedures using local anesthesia or mild sedation, and any liposuction that removes less than 1,000 cubic centimeters of total aspirate. If a physician conducts cosmetic surgery in an unaccredited facility or office, the penalty can be suspension, revocation or other disciplinary action by the Board of Physicians.

Health Emergencies/Governor's Order: MedChi introduced legislation for the second year altering the penalty for a health care provider who fails to comply with a Governor's Order during a "catastrophic health emergency" from a misdemeanor to an offense subject to discipline by their licensing board. House Bill 1190 (*Health Occupations Boards – Discipline of Health Care Providers – Failure to Comply with Governor's Order*) died on the Senate floor on the last night of Session when time ran out.

Current law permits the Governor to commandeer the health provider community, quarantine individuals and exercise other powers during a health emergency. But the law contains a criminal penalty for all who fail to comply, sweeping physicians who fail to report to an aid station in with citizens who fail to get immunized, for example. The bill would have carved health care providers out of the misdemeanor penalty and instead let their respective boards discipline them.

Primary Care Issues:

There were a number of initiatives enacted that specifically address issues related to primary care services and physicians. The General Assembly is cognizant of the increasing shortage of primary care physicians and the access challenges that arise as a result of those shortages. The legislation passed this year demonstrates recognition by the General Assembly that it must "fix" the challenges facing primary care if the State is ever to be successful in improving quality and controlling costs. The bills particularly germane to primary care are:

House Bill 929/Senate Bill 855 (*Patient Centered Medical Home*) – Enactment of this legislation will enable the Maryland Health Care Commission to establish the Patient Centered Medical Home Demonstration Project that was approved by the Governor's Cost and Quality Council in December of 2009. The demonstration project will seek to involve a diverse cross section of the primary care physician community, including diversity of practice size, demographics and geography.

The Commission will develop regulations that address payment mechanisms, evaluation tools and other aspects of the program. It reflects the culmination of a two year process that involved a broad range of stakeholders including the active participate of primary care physician specialties. The project has a five-year sunset but it is anticipated that data from the project will provide useful insights far in advance of the completion of the project.

House Bill 435 (*Health Insurance – Reimbursement of Primary Care Providers – Bonus Payments*) – As originally introduced, House Bill 435 proposed to require reimbursement for "visits" provided via email or telephonic communication. In addition, it required reimbursement for after hours care. The provisions reflected issues incorporated into Recommendation No. 6 of the final report of the Governor's Task Force on Health Care Reimbursement. The Maryland Health Care Commission and the insurers raised questions regarding the email and telephone service part of the bill and these provisions were deleted. Given the uncertainty of telemedicine regulation by the Board of Physicians, there was no objection to the deletion of these provisions.

The legislation as amended requires that an insurer must specifically address bonus payments for primary care physicians when they provide services to insureds between the hours of 6 p.m. and 8 a.m., weekends and holidays. The amount of the bonus payment is subject to negotiation with the insurer but must be specifically addressed in the contract. It reflects a desire by the General Assembly to incentivize behavior that will reduce the inappropriate use of emergency department services and to enhance the compensation of primary care physicians.

House Bill 878/Senate Bill 313 (*Health Insurance – Annual Preventive Care*) – In an effort to facilitate the scheduling of routine and preventive care, the passage of this legislation specifies that an insured can receive their annual preventive care visits at anytime during their plan year. The legislation's enactment will provide physician offices and their patients, flexibility in scheduling annual preventive services. Annual preventive services include annual child wellness visits; routine gynecological visits; screening or exams for colorectal cancer, chlamydia, HPV, prostate cancer, or breast cancer; and annual vision examinations.

House Bill 1017/Senate Bill 700 (*Health Insurance – Child Wellness Benefits*) – This legislation clarifies that the existing child wellness mandated benefit includes coverage for

developmental screening and obesity evaluation and management visits. While some carriers had been appropriately covering developmental screening, CareFirst, the dominant carrier in the market, refused to reimburse for screenings. With respect to obesity visits, few carriers recognized the ICD-9 diagnosis code for obesity, forcing physicians to identify other diagnoses for these visits. Passage of this legislation should result in enhanced identification of children at risk for obesity related health issues and enhance the ability and willingness of pediatricians to conduct the recommended developmental screenings.

Other Public Health Initiatives:

There were a number of other legislative initiatives that had public health implications. Those of particular interest included:

House Bill 411 (*Statewide Advisory Commission on Immunizations – Membership, Duties, and Sunset Repeal*) – The Statewide Advisory Commission on Immunizations becomes a permanent Commission as a result of passage of this legislation. In addition to removing the sunset, the bill adds a consumer and pharmacist member, creates three-year terms for all Commission members, specifies that the Commission Chair shall be appointed by the Secretary of DHMH and adds several important charges to the tasks of the Commission.

The new charges include a review of: potential provider reimbursement barriers to increasing immunizations; relative effectiveness of outreach programs that educate the public about the benefits of immunizations; potential cost-shifting of immunization expenses for privately insured patients who receive immunizations at public health departments; and the potential administrative burdens associated with State purchasing of vaccines. The Commission is also required to make recommendations on how to increase immunizations, including catch-up immunizations among adults, adolescents and children.

The enactment of this legislation enhances the strength and relevance of the Commission and helps to ensure that it becomes a more effective tool for policy makers in shaping initiatives relevant to immunization policy in the State.

House Bill 1036/Senate Bill 718 (*Tanning Devices – Use by Minors – Prohibition*) – MedChi sponsored an initiative in 2008 which successfully limited access to tanning devices by minors. Current law requires that minors have parental consent before they access tanning services. Since the enactment of the original legislation, Howard County has instituted a complete ban on minor's access to tanning services. This legislation proposed to eliminate the parental consent provisions and implement a ban statewide. The bill was defeated in both Houses.

House Bill 1391/Senate Bill 865 (*Education – Student-Athletes – Concussions*) – This legislation, which was introduced fairly late in the session, imposed various training and educational requirements for schools and recreation and parks programs related to student-athletes and concussions. The original bill also provided for various immunity provisions for those programs. The Senate passed the bill with amendments which deleted the immunity provisions and narrowed certain aspects of the training and educational requirements. The

House Ways and Means Committee did not take the amended version of the Senate bill and thus the legislation failed. Successful passage of the Senate bill does provide a framework for consideration in 2011.

Malpractice

Malpractice Reform Issues: The story of malpractice reform in the 2010 Session was "no runs, no hits and no errors!" The plaintiffs' bar attempted to **double** the cap on non-economic damages by filing Senate Bill 769 / House Bill 622 (*Health Care Malpractice – Noneconomic Damages*).

Meanwhile, Delegate Elliott proposed a reduction in the cap on noneconomic damages, House Bill 1157 (*Health Care Malpractice – Limitation on Noneconomic Damages*) as well as a proposal to pay out large jury verdicts over time, House Bill 1166 (*Health Care Malpractice – Awards and Judgments – Periodic Payments*).

All of these bills were heard before their respective committees but never received a vote.

One disappointment, however, was Senate Bill 358 (*Health Care Malpractice – Expression of Regret or Apology – Inadmissibility*) which was heard before the Senate Judicial Proceedings Committee and appeared to have the necessary votes to be passed. However, it was opposed by the Maryland Association for Justice (aka the Maryland Trial Lawyers Association) and never received a vote in the Committee. Leadership in the Committee was opposed to the bill and probably understood that it would have passed. The unfortunate thing is that this is the one "malpractice" reform proposal which does not appear to cost anybody anything. Yet, it appears to have had a positive effect for those hospital systems which have embraced the concept of disclosure and apology. The positive effects have resulted in reduced insurance cost and reduced litigation. Of course, reduced litigation is opposed by the "Maryland Association for Justice."

Medical Malpractice Insurance: Legislation was introduced that would have mandated that certain physicians carry medical malpractice insurance. MedChi opposed House Bill 1252 (*Physicians – Professional Liability Coverage - Requirements*), which mandated certain levels of malpractice insurance for physicians conducting outpatient surgical services in freestanding ambulatory care facilities. MedChi also opposed House Bill 1253 (*Physicians – Professional Liability Coverage – Proof and Notification*), which contained a similar mandate but also required that all physicians who do not have malpractice insurance disclose this fact to their patients. Senate Bill 402 (*Physicians – Professional Liability Insurance Coverage – Notification and Posting Requirements*), on the other hand, required only a disclosure and was supported by MedChi with some clarifying amendments.

MedChi took the position that the mandates imposed by the House bills should have been accompanied by the establishment of an insurer of last resort for those physicians unable to obtain insurance in the standard market. MedChi then worked with the Delegate Manno and he agreed to withdraw House Bill 1252 and to amend House Bill 1253 to mirror Senate Bill 402 (as amended). Ultimately, the House Health & Government Operations Committee was

unconvinced of the need for these bills and killed all of them, partly due to the fact that the government health insurance programs, private insurers and accredited facilities all require physicians to carry malpractice insurance, leaving a relatively small percentage of physicians who don’t have coverage.